FlexBen Corporation
PO Box 991
Mequon WI 53092
(800) 582-9740

Flex Convenience Card Expense Verification Form
(Only use this form for debit card receipts)

TO: FlexBen Corporation

ATTN: Linda Bauer

FAX #: 262-236-8409

PAGES: _____

DAYTIME PHONE: _____

EMPLOYEE EMAIL ADDRESS: _____

FROM: Employee Name: _____
Employer Name: CITY OF SALISBURY

RE: DEBIT CARD EXPENSE VERIFICATION

NOTE: Plan guidelines require documentation submittal when an expense is outside your employer's prescription/medical co-pay as outlined in your Summary Plan Description. Please attach your supporting documentation to this cover sheet and mail/fax to our office within five (5) days of using your card. Itemized statement/receipts must contain the following: 1) name of patient, 2) date of service, 3) description of service, and 4) service cost.

***Please submit claims that were <u>not</u> paid with your debit card separately on the FlexBen Corporation claim form. Only include claims paid with your debit card with this form.

PLEASE RETAIN THIS FAX COVER SHEET FOR ALL EXPENSE VERIFICATIONS